Quality Measures: Patient Safety Tiger Team
Draft Transcript
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Presentation

Neil Calman – Institute for Family Health – President & Cofounder
Welcome, everybody. This is the second meeting of the Patient Safety Tiger Team, which is a subgroup of the Quality Measures Workgroup, which is developing recommendations for measures of patient safety that we would suggest might be part of the meaningful use definitions in the future iterations, which are for 2013 and 2015. If there's anyone on the call that was not on the prior call, our job is not to develop the measures or the numerator denominator definitions of those measures, but rather to identify the key areas where we think measurement should be developed that would look at important patient safety issues that are amenable to IT intervention or measurement. We want to pick up this conversation where we left off the last time. So, if I might, I will take a couple of minutes.

First, I want to introduce our new coordinator of this Tiger Team from ONC, Leah Marcotte. Do you want to just say hi?

Leah Marcotte – ONC
Hi, everyone.

Neil Calman – Institute for Family Health – President & Cofounder
She will be supporting the Tiger Team through this and I guess the third and last call that we have scheduled. Where we start off today is kind of where we left off last time. I'll try to summarize that. If anybody has any other recollections about things that I'm not speaking of, you can jump right in.

We were trying to define the sub-domains or categories that we would be working in. The ones that we had defined were medication safety, infection prevention, falls prevention, and a fourth one which we hadn't fully explored was about venous thromboembolism and its prevention. Within those domains, we discussed a number of things. The first was that we needed to understand the extent to which IT could serve to prevent these adverse events for patients. Obviously, those are the issues we're interested in because we're trying to get measures that would show that people were meaningful users of information technology.

The IT might serve in one of two capacities. It might serve on the sort of prevention side. That having the IT would improve our outcomes and therefore reduce the number of adverse events or safety problems that we have. It might also be that IT enables us to report on those events. When I say report, specifically I believe our discussion was focused on internal reporting for the purposes of quality improvement, not external reporting, which is a completely different beast. So, what we're talking about is we're interested in improving the safety of organizations, feeding into their internal quality improvement mechanisms by giving people in those organizations information about the events that are taking place.

Then we have to also think about how that reporting plays out to CMS because part of this has to be an ability to show that the systems are being meaningfully used so that people can qualify for the incentive payments. We also talked about reporting in two categories: both reporting on actual adverse events and also reporting on near misses as an important aspect of quality improvement, something that's been shown in other areas.

So, just to summarize, today what I'd like to do is I'd like us first to lock in on the areas, the sub-domains, make sure that the four that we've pulled out are the ones that we want to stick with. We want to talk about, in each of those domains, the extent to which IT can play in enabling role in either preventing adverse events or in helping to report them, both of which are valuable. In reporting, make sure that we both capture actual events and near misses, and again, make sure we stay focused on internal reporting

for the purposes of quality of improvements, but not to lose sight of the fact that we also need to think about what would be reported to CMS in terms of demonstration that we're meaningfully using electronic health records systems.

So let me stop there quickly and ask if anybody else on the call who was on last time's call has anything to add or any different recollection of what took place.

Tripp Bradd – Skyline Family Practice – Physician
I think Russ brought up never events as also an additional thing, although I'm not sure how that fits in.

Russ Branzell – Poudre Valley Health System – CIO
I think the other thing we discussed was being able to—and relative to these sub-domains—being able to take advantage of anything that's already being established across the country as safety standards such as national patient safety goals or the define never events, those types of things, and whether those fit under the buckets we've already defined as well.

Neil Calman – Institute for Family Health – President & Cofounder
I hope everybody was able to access the SharePoint site. There's a lot of valuable resources there. Some people have actually added content to those sites, which is greatly appreciated. Any other comments about things that need to be added or discussed?

Okay, then the first task that we were given was actually the finalized sub-domains. I believe they wanted us to finalize approximately three. So for me, that means anywhere between two and four, but not eight. Do you want to speak up on what your feelings are about the domains that we just mentioned and how comfortable you feel with those and if there are others that we should be considering?

Russ Branzell – Poudre Valley Health System – CIO
Well, I think that the first three, the way you defined them—medication, infection, and falls—seems like a good starting three and the … question is do we add an "other" or something else if it doesn't fall within those categories but we still deem it appropriate? I can't personally think of an overarching other category by name, but rather we may have something that falls out of those three, we want to have a bucket to stick them in.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
I'm delighted to be able to join today. I'm comfortable with those three. I, myself, would favor addressing DVT and its prevention in some form. Whether it's its own category or whether it's a sub-category of medication, I'm agnostic about.

Neil Calman – Institute for Family Health – President & Cofounder
Well, we could sneak it into medication so that we could stay within our three goals, but I think we all feel that it's important.

Leah Marcotte – ONC
I just want to bring up; we can have more than three sub-domains. The other groups have far more than three.

Tripp Bradd – Skyline Family Practice – Physician
Well, we want to be parsimonious.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I agree.

Leah Marcotte – ONC
Yes, I totally agree, but if we have five instead of three, that's totally fine. This was also brought up in the ONC Meaningful Use Team meeting that in addition—the parsimonious, we don't need to worry about

overlapping with other groups as well. So if something falls into another group, we can just leave it and then in the overall workgroup we can revisit that.

Neil Calman – Institute for Family Health – President & Cofounder
What I'd like to do is I'd like to then explore these things in the following manner. First, let's have a discussion about—and we'll take them one at a time—the extent to which we think information technology can be used to prevent adverse outcomes: medication errors, infections, falls, embolisms. Whether or not IT is helpful in actually documenting and reporting those events so that the circumstances around them could be examined for future quality improvement efforts. Also, let's think about what it is that we would think could be reported to CMS in relationship to proving that people were meaningfully using their systems.

Let's start with the medication safety. You all got a copy in a recent e-mail from Leah of the sheet that we're working on called Patient Safety Sub-domains. It's a long spreadsheet with multiple columns. It lists the sub-domains, not exactly how we talked about them, but has some comments and stuff like that in a number of categories. We could use that or not, just depending upon whether you think it's helpful. So, let's talk about the medication safety piece.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Well, I think this is probably the biggest one of everything in there, not that all of the rest aren't important. I think that this is an area that obviously, based on the stage one standards and as stage two is pushed harder that there's lots of opportunities here whether it be through the standardized bedside med verification, CPOE, order sets. IT, I think, will be a huge enabler in this area. Alertings, flags, intelligence in the clinical system; I think this is one that—I won't say it's easy, but this is an easy one for IT to affect.

Neil Calman – Institute for Family Health – President & Cofounder
How about on the outpatient side?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
With the ePrescribing, there should be as well. For the physician side with the ambulatory EMR, there should be quite a bit with ePrescribing built in there with alerts, rules, and standardized order sets for that as well.

Tripp Bradd – Skyline Family Practice – Physician
Did anyone have a chance to look at the study that was recently released—online publication, the medication prescribing and monitoring errors in primary care? Has anyone had a chance to look at that at all? It was on the extranet.

Neil Calman – Institute for Family Health – President & Cofounder
No. Could you summarize what the findings were for us?

Tripp Bradd – Skyline Family Practice – Physician
What it did was it looked at a group of practices that used one EHR to look at different categories, such as potentially inappropriate treatment, inappropriate dosing, drug-to-drug interactions, drug-to-disease interactions, and monitoring or prevention of adverse drug effects. It was actually reached at through a consensus, but then subsequently verified by research, but it was actually, I thought— and I was one of the participants in the study. That's why I feel the pain of the study—but I think the thing was it was actually a lot easier as a participant and a user of an EHR by virtue of the fact that the data was extracted using those parameters.

It did not address other things such as therapeutic duplications, for instance somebody who's on Bumex and Lasix, or untreated indications or medications without an indication. The reason why this was meaningful use, in a sense, was it was HIT sensitive. It actually led to behavior changes in the clinicians, in terms of their prescribing habits, some of which, they weren't generally knowledgeable about. A good example would be creatinine clearance and allopurinol use. Just to use that as an example, a lot of patients were getting 300 mg of allopurinol, and their creatinines were well over, for instance, 1.5. It's

worth looking at it, not necessarily point by point or measure-by-measure, but how it really did make a difference in terms of the measures. That's a summary, I guess.

Neil Calman – Institute for Family Health – President & Cofounder
The thing that's impressive about that is that there was lots of measures where very few groups were meeting the benchmark.

Tripp Bradd – Skyline Family Practice – Physician
Correct.

Neil Calman – Institute for Family Health – President & Cofounder
Of the practices, which shows how much mileage there is to go between where we are now and where we could potentially be.

Tripp Bradd – Skyline Family Practice – Physician
Where they performed the best, of course, were drug-to-drug interactions because of the internal EHR settings for looking for those things. That's a measure that would be easy to make for a lot of practices using an EHR.

The harder ones were, for instance, monitoring for adverse drug effects. Let's say a diuretic and monitoring potassium, for instance, or a digoxin level … and monitoring that. So, we think we do well, and that was the thing that I've always been impressed with. Clinicians always think they do better than they actually perform until they actually see the data.

Neil Calman – Institute for Family Health – President & Cofounder
Were the numbers that were published in the chart, in that article, were they pre-intervention in terms of putting decision supports in the system to try to improve those outcomes?

Tripp Bradd – Skyline Family Practice – Physician
No.

Neil Calman – Institute for Family Health – President & Cofounder
In other words, this is people's raw activity of—

Tripp Bradd – Skyline Family Practice – Physician
Yes. It represents process improvement. This particular EHR does have, for instance, the ability to have discreet data elements, but those things were tracked. But in actual fact, it involved— No, there was no pre. We just went into it and then at certain measure points, decisions on how to improve things were shared with those particular practices, again, the extraction and then the feedback to the clinicians, thereby making it really meaningful.

Some things were always hard to perform with. A good example would be, and I don't want to spend too much of the committee's time, but NSAIDS and hypertension. That was a hard one for some of the practices to meet, but at least they knew about it. It did, in fact, make them knowledgeable about the changes they needed to make.

Neil Calman – Institute for Family Health – President & Cofounder
So anyway, the take home message for us is that this is an opportunity for great quality improvement and great increase in patient safety on the outpatient.

Tripp Bradd – Skyline Family Practice – Physician
Correct.

Neil Calman – Institute for Family Health – President & Cofounder
I think we can star this as one of the categories that we're not going to eliminate. Now, the question within medical safety, as with the chart that's in that paper, I think the chart had 30 or more different types

of safety issues in there. That's only a sub-set of all the ones that we could think of, of which there's probably thousands. What might our recommendation be about those that are most critical and most dangerous? Because my sense is providers sort of innately pay attention to those things that happen—bad outcomes that happen—frequently and are severe and we kind of all know what those are in our head, but it's the ones that are less frequent or less severe that are the ones that are easily overlooked.

How are we going to come up with some recommendations for specific measures here that we could recommend? Again, I'm not looking for numerators and denominators, just kind of like what would we do. There are many on that paper that you could adopt very easily.

Russ Branzell – Poudre Valley Health System – CIO
I do have a question on that from a process perspective. Not disagreeing we need to get down to specific measures, but is there a level above that that we want to mandate from a monitoring perspective, whether that be utilization of some kind of whether it be clinical intelligence or evidence-based repository for these protocols as a percentage of utilization like we've done for the other standard side of this, which is meds administration, whether outpatient or inpatient, must be done via some form of evidence-based, some nationally accepted evidence base for starting off 50% of all orders? Or maybe we start out with it as structured as 100%, which would lead into those specific measures.

Neil Calman – Institute for Family Health – President & Cofounder
Even if you said 100% of all orders had to be entered into a system, the question that one would raise is what are we going to require that system to contain? So, are we requiring the system to check drug-drug, drug-disease, drugs in the elderly, drugs in pregnancy, drug allergy? What are we doing to require that system to do? Then maybe from that point, you could jump right into kind of like what would we measure. I think it's a good question to sort of stay at a higher level and say, "What do we really think the system should be able to do?"

Tripp Bradd – Skyline Family Practice – Physician
If you look at the meaningful use stage one, we've said drug-to-drug, drug allergy and drug—I don't know. I forget what the third one was. But, the interesting part to that is it doesn't necessarily mandate the utilization of standards for that other than checking it. The examples that people were giving earlier is do we mandate the system hardwire in their appropriate use of things based on evidence, which it seems like that's still the part that's missing in that whole equation.

Leah Marcotte – ONC
Just from a meaningful use perspective, I know that we're going to try the stage two to provide more of an evidence base very clearly, so I think that fits in well to this discussion.

Neil Calman – Institute for Family Health – President & Cofounder
Still we have to figure out how we would call that out. Whose evidence? The discussion about whether or not this content should be built in by vendors or built in by providers themselves is one that we had even in the stage one meaningful use discussions.

For example, in medications in the elderly: One of the comments that was made, I remember in the discussion, was, "Yes, we could put in the medications with adverse effects in the elderly and it includes lots of psychotropic medications," but guess what? If you were a geriatric pharmacologist using the system, you would be using lots of medications that were contraindicated, well, or at least that were on the Beers list because specialists often are called upon when the common things fail and they go to the therapies that are less commonly used by the primary care provider. The questions were how would we measure that? Are we just measuring whether people have systems that use it or are we measuring whether people pay attention to those alerts when they come up? Or are we measuring whether at the end of the day, the numbers of patients and the numbers that have been prescribed medications that might be contraindicated? There's some really complex measurement questions here.

Tripp Bradd – Skyline Family Practice – Physician

Using your geriatrician example of— I am one. But I will tell you that if somebody really had a predilection, using an example, for prescribing Flexeril for everyone who had any back pain in an elderly patient, I would hope that someone would hold me accountable to that at some measure by some way. Rather than managing by the exception, which in this case, it would be, I would rather be more comfortable with a measure that does spell out those particular drugs. Then if someone starts falling out, they're an outlier and they can explain why.

Neil Calman – Institute for Family Health – President & Cofounder
So where does the content come from? That's really the critical issue. Where does the knowledge content come from? I know the vendors have been reluctant to add a lot of this knowledge content because they feel like there's some liability associated with it. There's a responsibility to keep it updated every time new studies come out showing things. So where would we think the knowledge content should come from when we use the term evidence-based?

Tripp Bradd – Skyline Family Practice – Physician
This is where it's going to become difficult and I'm not sure we should be the one defining that or maybe we are the ones to define that, but I think actually the vendors are trying to, and actually several of them do allow the import of an evidence-based repository and some will actually allow you to even do your own. That's really the question. Is a health organization such as myself—multiple hospitals, critical access hospitals—are we in the right position as a community health system to be defining our own evidence base? Or should we be using a national standard and move into that with whatever it is—a Walters … or Mayo's Nationally Accepted or whatever? Maybe that is our task to do.

Neil Calman – Institute for Family Health – President & Cofounder
Well, I don't think it's our task to recommend one, but I think we would want to call out that we think there should be loaded into the system some database of alerts for major drug adverse events which would include all of the categories that we're talking about—drug-drug, drug-allergy, drug-disease, drug-lab, drugs in the elderly, drugs in pregnancy, dosage checking in pediatrics—all of those areas. That the vendors should provide a model that either supplies that or supports the ability to import those kinds of databases into the systems. That the providers would be expected to use such evidence-based content in their practice. I mean, that sounds to me like a pretty reasonable recommendation. Could we just put that on the table for discussion? Could we recommend that?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
That makes good sense to me. I think that we'll need to think about it in the context of each specific measure because there are a lot of measures that— If here we're talking about specific medication side effects in the elderly, it seems to me that it probably makes sense to do that once nationally. There may be other measures that we talk about that are highly dependent on local prevalence or local population or something else that's very local. So it seems to me that we'll have to think carefully about this kind of thing, measure-by-measure. There may not be a single, silver bullet solution that works for us all the time.

Neil Calman – Institute for Family Health – President & Cofounder
I'm actually not recommending that. What I'm recommending is that our recommendation would be, number one, that vendor systems have the capability either by building knowledge content into the system and/or by providing the ability for those systems to import knowledge bases from other sources to provide decision supports in the areas of drug-drug, drug-disease, drug-lab, drug-allergy, medications in the elderly, dosage checking in children, drugs in pregnancy and lactation. To provide the ability to import that information or for users to develop that content so that the systems would be required to do it. The users would have the ability to import that content or develop it. Now we have to say how do we measure whether they're actually using that in a way that's certifiable to CMS?

But I'm not suggesting that on a measure-by-measure basis we look at every drug or every interaction or anything like that. I think that would be far too granular for us to do—not just our Tiger Team, but I think even for ONC to do. What we really want to do is call out that we want the systems to have that

capability, and now we have to figure out how we're going to measure people's meaningful use of that. Do you—?

Russ Branzell – Poudre Valley Health System – CIO
I agree with you. I think that's exactly the direction we need to go because the requirements even now are very, very simplistic to even have the capability to do one when you consider how much evidence that's out there. I keep referencing Zynx as an example. I just went to their Website, just to get the most recent information. There's 1,700 hospitals so far that have some access to this repository. There's 950 different pre-built evidence-based order sets. Just the use of some of those would reduce costs, would improve safety, everything that we've tried to, but there's not a mandate to orchestrate that and hardwire it into our EMR at this point. So I think this is exactly the right direction.

Neil Calman – Institute for Family Health – President & Cofounder
So, again we would call out that it could be hardwired or it could provide a capability for people to load third party content.

Tripp Bradd – Skyline Family Practice – Physician
Yes, I agree with Russ. I think also—everyone talks about delta points—the changes would dictate what meaningful use is because the behavior is changing. Wouldn't you agree? In other words, the measures change because they've been extracted and compared and they show a change. That's really what we're trying to do anyway.

Neil Calman – Institute for Family Health – President & Cofounder
I don't know if we could—and I guess this is something we would need to check in—I don't know if you could use a delta point here. If somebody's first implementing their electronic health record and ... decision point come in from day one, we don't really have any data on the pre-implementation part of this. I guess for some of us that have had systems that don't have all of this, we might be able to get data on a delta, but if somebody's implementing a system and wants to get meaningful use dollars, we're not going to really have the ability to go back and extract their rates of potentially adverse prescribing prior to the implementation.

Tripp Bradd – Skyline Family Practice – Physician
Well, just to use an example—I know Peter will probably agree with me—just measuring PT/INRs in someone on Coumadin and just seeing those— Gee, all of a sudden, they're finding out that their patients are not getting it every month like they thought. So, yes, you're right. Pre-implementation is what it is, but you still have to deal with— Maybe I'm just trying to make it more than it is, is trying to make a change.

Neil Calman – Institute for Family Health – President & Cofounder
We've just required the country—all the vendors to build this capability into their systems. So now all the providers have this. Let's think of a measure that we could suggest would demonstrate that providers are using that functionality in the system.

Tripp Bradd – Skyline Family Practice – Physician
Well, I'd say using, just having finished the study, I will tell you that as a clinician, I had patients on Coumadin and knew they were getting INR somewhere. I didn't actually prescribe it, but I was—this talks about coordination of care. But they would be on Coumadin. I'd know that but I would assume and expect to know what those INRs are, but I never got those results. This actually helped us to develop ways of getting those INRs to the chart if we did not do them. If we did them ourselves, we started really monitoring it a lot closer. So that's just one measure. Another one would be, of course, the Beers criteria for inappropriate meds in the elderly. I mean, that's a slam dunk.

Neil Calman – Institute for Family Health – President & Cofounder
So we know what the content is, but I'm asking a slightly different question, which is now you're going to CMS saying, "Pay me my incentive dollars." They say, "Well, we know this ... built into your system. How do we know you're using it?"

Tripp Bradd – Skyline Family Practice – Physician
So it seems like, similar to CPOEs measure and that formula that's being created or is being tweaked, this would start out with more of a basic concept of a utilization, then drive into a specific measure that monitors the outcome. So the first measure would be a utilization measure, it would seem like. If we say people have to use CPOE, that's great, if they're just putting in electronically. But if the CPOE has to be supported by evidence-based both protocols and order sets, then we say, "Okay, I'm great. Now I'm finally at 100% CPOE." Of my 100%, what percentage is using those following other things? If it's 2%, we may have just defeated the purpose of CPOE.

Neil Calman – Institute for Family Health – President & Cofounder
Have you looked at all—and we're just starting to do this—does your system have the capability of looking at the number of times that decision supports alert— Now this is not about order sets. Well, I guess it could be too, but I'm thinking of it specifically around alerts and warnings kind of types of alerts—the number of times the providers heed the alert versus bypassing it?

Tripp Bradd – Skyline Family Practice – Physician
There is functionality and I believe, and I'm probably making an over-generalized statement, but most of the major systems have the ability to turn that alert or if you hardwire the mandated requirements, when they override that you can create a report for when and how that was overridden and report that data.

Neil Calman – Institute for Family Health – President & Cofounder
So I think that, from my perspective, that would be what I would want reported, would be the ratio of alerts heeded versus overridden. That way, you don't have to get into each alert and figure out what was done. But basically, you go to order a drug, the warning comes up. Did you still go ahead and bypass it and order the drug or not? Of course, we're not looking for 100% here, the benchmark, but I think you're looking for some benchmark that shows that at least 50% of the time, people did what they were supposed to do, maybe just to throw out a number, as a first kind of benchmark. That, to me, would say yes, that there's use of the decision supports that are in the system.

Leah Marcotte – ONC
I think we just need to be careful with that because if you don't have a set number of alerts, so there's so much alert fatigue, that if you don't have everyone using the same number of alerts, that number to determine becomes a little hard.

Tripp Bradd – Skyline Family Practice – Physician
I think the other part to that is there's a difference between saying that a physician did the right thing. The right thing may have been to override the mandate given a unique environment, and we're having some pretty significant discussions at our organization about that because we have an entire physician committee putting together standardized order sets across the organization, using the evidence base. What they're trying to say is there's a fine line between mandate being a care protocol and the flexibility for a physician to appropriately take care of the patient given the unique circumstance.

Neil Calman – Institute for Family Health – President & Cofounder
Absolutely, and that's why I said you would never use 100% as your benchmark. Not because only 50% of the people are going to pay attention to it, but you want to create a level at which your expectation might be reasonable across the board.

Tripp Bradd – Skyline Family Practice – Physician
So the way we've tried to define that is we want 100% utilization of the standardized orders with only appropriate deviations from that care.

Neil Calman – Institute for Family Health – President & Cofounder
That's not something you could report to CMS, whether or not it's appropriate exception. What we're trying to do is reduce the reporting burden, right? So part of this is you want those reports to be able to

be generated in an automated fashion and to set thresholds that you don't have to microtune in order to figure out whether people are doing the right thing.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
That kind of a measure where it's hard to know at the global level what the right number is, whether it's clear— You've said already that the right number isn't 100, but based on the provider and the population the "right number" might vary greatly. That wouldn't be my first choice for a measure.

Neil Calman – Institute for Family Health – President & Cofounder
What would be your first choice or what would be a choice?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
From where we are now, just a use measure would be something. The kind of measure that you were talking about strikes me—for that measure to be useful, it would really have to be associated as somebody just said with some kind of assessment of whether deviations were appropriate or not. As you said already, the appropriateness assessment is probably more than we can do at the moment.

Neil Calman – Institute for Family Health – President & Cofounder
I'll try to push this one more time and then give it up. You don't think there's a threshold that would allow for that kind of variability that would demonstrate to CMS that people are using the functionality, which is all we're really required to do at this point? Say you set the threshold— Are 50% of the people complying at a 100% level with the order set? Are 50% of the times that the order set is used, is it being used at the 100% level? People are using it exactly as defined. In other words—

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Well, I think you could … this again. You could say all order sets in the system have been developed using a nationally recognized, evidence-based order set. We can hold that to a standard, saying—we could say that this is a defined standard 50%, 90%, whatever we think is appropriate. But then you could say then maybe it's not as much a mandate for stage two, just a reporting requirement. What percentage of orders were put in using that national standard? So if you have two organizations right next to each other that are seeing all the same type of patients and all of them are using standardized evidence base, but one's only meeting the requirement 50% of the time of that. What's different? Which is what we're trying to get at is to get people to explore clinical variation.

Neil Calman – Institute for Family Health – President & Cofounder
I like that. I think that's a very good alternative way of doing it. So basically, what you're saying is, so you define a condition. Let's say admissions for—I don't know, pick something that uses order sets most of the time—admissions for pneumonia?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Pneumonia. As a matter of fact, ironically, I just looked at our chief medical information officer's list he's rolling out this week. One of them is pneumonia.

Neil Calman – Institute for Family Health – President & Cofounder
Okay, so you have admissions for pneumonia and you would look at the extent to which admission orders were made using the standardized order set.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Correct. So the first measure would be what percentage of all your order sets developed in your system, were they built using evidence-based? Second was what percentage of that order set was used that way for that normal admission?

Neil Calman – Institute for Family Health – President & Cofounder
So the second, you could report on electronically. The first is completely out of scope. Nobody's going to sit and evaluate order sets and figure out whether or not they're evidence-based and get into arguments between providers and the government as to whether or not it is or isn't evidence-based. But I don't think

we need to worry about that because if people are developing order sets, I would trust that for the most part, people are developing them based on some discussions, whether it's consensus in their organizations or outside documentation or something.

I think we've created the capabilities in the systems to build them. We've created the capability in the systems to modify them and to import them. Now, you could just jump right to the last part, which is to say, "Here are two or three conditions for which we think the vast majority of people admitted with these conditions should be admitted using standardized order sets. Let's look at the extent to which people admitted with that condition had their admitting orders done through a standardized order set or not, period." I think you've then dealt with the capability of the system and the utilization of the order sets.

But I don't think you could deal with the middle part, unless somebody disagrees with me. I don't think there's any way that people could go look at every order set and determine whether it's evidence-based and by whose opinion. How does that sound? Is anybody still there?

Leah Marcotte – ONC
I think that sounds good. I think we also just need to bring this concept back to medication safety, though.

Neil Calman – Institute for Family Health – President & Cofounder
This is medication safety.

Leah Marcotte – ONC
Well, just in terms of talking about admission of order sets versus putting in medication orders.

Tripp Bradd – Skyline Family Practice – Physician
So as part of the outpatient EHR, we're going to have hospital admission sets that are going to be measured?

Neil Calman – Institute for Family Health – President & Cofounder
No, that's just part of inpatient. So recall that what is developed under each category are measures that are either hospital related, or as I call, eligible provider related, or both. So the order set stuff that we just talked about would be more hospital related. Now we can go back to the ambulatory care environment and say, "What is it that we want to look to there?" and that might have the equivalent kind of situation. So, I think that the building in of the decision supports/order sets into the system is a system functionality that's relevant to both ambulatory care and inpatient, but now we need a measure that's more relevant to ambulatory care.

Russ Branzell – Poudre Valley Health System – CIO
Well, is there stuff in the ambulatory care that's relative to the medical home demonstration areas and pilots relative to the disease cases that are there? Because I know they're developing standard protocols and order sets relative to disease management in those areas. Diabetic hypertensives, whatever … those. Then there's standard evidence-based on how they should be managed, which also is going to drive us to a more specific measures that we may very well want to deal with with the use of certain drugs with hypertensives or whatever the case may be. So it's kind of that cascading effect down. It would seem like there's somebody that's gone out a little bit ahead of us on this, especially with the medical homework done, that feeds into this, similar measures.

Neil Calman – Institute for Family Health – President & Cofounder
I don't want to get too deep into quality improvement stuff. So a lot of that work's been done around quality improvement. On the patient safety side, I think we should sort of work our way back to the preventing adverse events piece of this and start asking more about how could we measure whether or not people are paying attention to the alerts they're getting about potential adverse events.

Russ Branzell – Poudre Valley Health System – CIO

That's very much built into most of the major ambulatory EMRs at this point. We've got the ePrescribe requirements that are going to get elevated at stage two. As part of that are the things that you've described equivalent to the same things in the hospital side. Are those mandated? So the same would be true. Do they have that stuff turned on and if they do, what percentage are being appropriately checked and utilized?

Neil Calman – Institute for Family Health – President & Cofounder
Well, if it's turned on, they're all being checked. The question is, are they heeding the advice of the warnings or bypassing them?

Russ Branzell – Poudre Valley Health System – CIO
If the system's set up correctly, it should be able to trace when that is overridden or bypassed as a document into the EMR. If it's not, that's what we should be mandating … to track that.

Neil Calman – Institute for Family Health – President & Cofounder
Right. So that would be a requirement for certification of the systems. That they have the ability to report on, for decision supports, the extent to which they're heeded or bypassed. That would be something that the providers could report on with no specific threshold. Just we want them to report on it for the purposes of looking at it themselves and for internal reporting so people can say, "Wow. Joe's not paying attention to any of the alerts."

Tripp Bradd – Skyline Family Practice – Physician
I know, and correct me if I'm wrong across the committee here, a lot of these systems allow for levels of drug interaction checking that would allow— For instance, you could set a severity level as very low for a minimum level so that you pick up most problems, then you'd have to bypass through them. On the other end, you'd have levels that were set so easily, let's say, so that they're virtually—you'd almost breeze through your prescribing if you weren't paying attention. Is that something that would be relatively— What I'm trying to say is that you can set it at so many levels. There's so much configurability amongst the systems, that this may be actually a harder measure than on surface appears.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. Some systems allow ... scales of levels to be done, like, the frequency of the event, so if it's incredibly rare or if it's common, and then the severity of the event. So if it's common but not important, and then how would we determine that? So we might end up in a very—and I don't suggest that we should do this in the Tiger Team because we're not paid enough, but somebody might want to look and start digging into this and think about kind of a minimum or course set of these that could be used that everybody would agree are both important and common enough in relationship to the type of events that have happened.

I actually asked our pharmacist if there was a mechanism, of these numbers of 800,000 adverse drug events reported every year, if there's a break down by drug and by what the adverse event was, but I haven't gotten an answer yet. I don't know, maybe somebody else knows the answer to that. But if there is, it would be good to look at the things that have the highest frequency and the highest potential adversity and start with those as kind of a course set.

Russ Branzell – Poudre Valley Health System – CIO
I think somebody said earlier, the real key here is making sure we don't mandate a system that is so obtrusive to the physician's workflow that we've given them fatigue and they don't want to even use it. We did that when we turned on one of our ambulatory EMRs. The system had notifications, alerts, and critical errors. They were getting for any given prescription or even order in the system like ten alerts. They just started ignoring them. Finally they said, "Shut off notifications and alerts and only leave on critical errors," which was almost nothing. We just want to make sure we're doing the right thing that doesn't harm workflow, but at the same time, meets those needs. I don't know what that answer is, but it's a fine line that we won't get massive pushback if we put too much of an intrusion ....

Neil Calman – Institute for Family Health – President & Cofounder

So I'm wondering if maybe the staff could look at for us—Leah, or somebody there in Washington knows the answer to this—is to whether or not the adverse drug reporting system has reports available by frequency so that we could look at what may be the top five adverse drug reactions that were reported, and call out potential of a core set? I think that would be helpful because it would deal with this issue of number one comparing providers between each other so that somebody's not looking at the rate of acceptance in a system that has 7,000 measures versus the rate of acceptance in a system that has 7 measures.

Leah Marcotte – ONC
Yes, of course, I'll be happy to do that.

Neil Calman – Institute for Family Health – President & Cofounder
Let's just jump to the adverse drug reporting piece. I think another huge potential benefit of having an electronic system is to be able to improve the rate of adverse drug event reporting in the country. I think that that's—I forgot the number. I read it, but it's 650,000 or 800,000 or somewhere in that range of adverse drug event reports that are received every year. It's thought that that's probably a small fraction of the number of actual events, both because people don't realize that something they're observing is an adverse drug reaction, and also because the reporting systems are terrible.

One of the thoughts here would be—on sort of a second tier—to create a ready mechanism for systems to be able to hit a button, so to speak, and load up information electronically from the system that could form the basis of an adverse drug report and to automate the communication of that to the national system. What are people's thoughts about that as an idea? Make it easy to file a report.

Tripp Bradd – Skyline Family Practice – Physician
I'm all about easy, but the question is how we're going to measure it, I suppose.

Russ Branzell – Poudre Valley Health System – CIO
This just goes back to your previous comment. If we mandate something like that, is that a standard report that has to be initiated within the EMR, therefore being filed with standard information in it, therefore easily extracted and reported?

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Russ Branzell – Poudre Valley Health System – CIO
To be honest, I don't think that would be that hard if we could get somebody out there to define what the appropriate standard codified information would be that would have to go into the quality module, whatever part of an EMR, would monitor that and report on it.

Neil Calman – Institute for Family Health – President & Cofounder
So, we'll ask staff to bring up the copy or get us a copy of that form, but I believe there's a standard form for reporting adverse drug events.

Tripp Bradd – Skyline Family Practice – Physician
Yes. DEA does have one.

Neil Calman – Institute for Family Health – President & Cofounder
Into a database. I forgot what that database is called. But, it's in the spreadsheet that I sent out.

Russ Branzell – Poudre Valley Health System – CIO
So then you go to what is the measure. It would seem like this would be, at least in my mind, an absolute measure, meaning all would be entered into the EMR and all would be reported using that format.

Neil Calman – Institute for Family Health – President & Cofounder

Right, but there's no way to know that. So if we want to just make sure that you are a meaningful user of this EHR, so we would require the EHR vendor to put the capability in for like a hot button adverse drug effect kind of thing. Then we would require you to show that you've used it at least once in a year or something like that—I don't know—or used it at all. But then we know that you can use it and we know that it's available on your system.

I don't think we could monitor numerators and denominators here in terms of how many, what percentage of drugs it got used on, whatever. We surely couldn't do make sure you reported every adverse event because we have no way of knowing what the denominator is.

Russ Branzell – Poudre Valley Health System – CIO
But what you could mandate is that every report came from that system.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Another way to think about that is that— It strikes me that that issue is less like the other quality measures that we've been talking about. It's more like the public health uses in meaningful use, like your system has to be able to report to immunization ... information systems. As we move to stages two and three, you might take that kind of an application and add it to the list of the first three public health uses.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, I don't even know whether the national system is capable of receiving this electronically. Even if it's not, the ability for somebody to hit a button that could extract most if not all of the reporting of the information needed for reporting would greatly facilitate that report.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Yes, for all the public health uses, the … immunization information ... electronic laboratory reporting … surveillance ... the receiving sides are having to build infrastructure in the same was that the sending sides are having to build capacity and infrastructure. So if it were true—and I don't actually know what FDAs able to receive right now, but if it were true that the receptor side isn't ready yet, I'm not sure that that's something that should dis-sway that, per se, from thinking about it.

Neil Calman – Institute for Family Health – President & Cofounder
Right. I think what we've been talking about in the public health arena for 2013 is a requirement that the systems can generate a report easily and that they have the capability of sending that report in a way that the health department is able to receive it. Whether that's by fax or by batching them or by sending them electronically. So I think we could create the same kind of flexibility here.

Russ Branzell – Poudre Valley Health System – CIO
Yes. I think we need to try to be as prescriptive on the EMR functionality side as we can on that, and I'll use Hcast as an example. It's very frustrating, I know, for our clinical and quality staff here to try to gather all the information necessary to report on Hcast because it's not in an easy, reportable, standardized, codified manner because the EMR doesn't support that. If we can get to that point for these type of things, it will be easier and it will be easier for the government as well to actually accept this in a standardized way.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. So we will find that information out.

Tripp Bradd – Skyline Family Practice – Physician
It's actually called the adverse events reporting system that—

Neil Calman – Institute for Family Health – President & Cofounder
AERS. That's right. AERS.

Tripp Bradd – Skyline Family Practice – Physician
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
We'll find out what the capability is there and figure out how that can be worked into our plans. Okay. Well, I think very handily we've dealt with lots of different types of drug medication safety stuff. Is there anything else anybody wants to bring up in this area before we move on to the next one? I almost feel like we shouldn't push our luck, this was so good. Alright.

Let's go on to infection prevention. What's the role of IT here in assisting us to reduce infection rates in hospitals?

Russ Branzell – Poudre Valley Health System – CIO
Well, again, I think part of this is going to be the front end alerting process. So if someone's presented with an initial diagnosis of some kind of infection or whatever the case may be, are we alerting in the system such a way that those things that should be mandated by protocol are hardwired into the system and alerted to the caregivers rather than just built in there for documentation?

Neil Calman – Institute for Family Health – President & Cofounder
So can you give an example, because—

Russ Branzell – Poudre Valley Health System – CIO
Antibiotics prior to surgery: Is the system sending off fireworks and alarms to make sure that nobody forgets to give the appropriate antibiotic at the appropriate time? Or is it the system supports documenting it, but there's really nothing other than a human being remembering to do it at the right time?

Neil Calman – Institute for Family Health – President & Cofounder
Are there other examples?

Russ Branzell – Poudre Valley Health System – CIO
I'm sure there are.

Neil Calman – Institute for Family Health – President & Cofounder
Would that fit into the order set kind of thing? Like you're writing pre-op orders and it comes out in an order set?

Tripp Bradd – Skyline Family Practice – Physician
You're saying a sub-domain of the sub-domain? Of medications—

Neil Calman – Institute for Family Health – President & Cofounder
I'm just saying whether or not that's a separate process from what we've called out in the order set thing.

Russ Branzell – Poudre Valley Health System – CIO
I mean, I'm no expert on infections by any means whatsoever, but it would see like part of this is more the alerting process rather than— Part of it is definitely order sets, but it's not just that the order set's in place. It's that the alerting mandates it occurs at the appropriate time, the appropriate dose, all those type of things, and the appropriate drug being used.

Neil Calman – Institute for Family Health – President & Cofounder
Other ways in which IT can help to prevent infections?

Leah Marcotte – ONC
Some of the measures that were in—I can't remember if it was Gretzky Group of the Appendix C, but were the ventilator, associated infection prevention checklist, a central line infection prevention checklist, alerts to remove bullies 24 hours after surgery.

Peter Briss – CDC – Medical Director, National Center for CDP&HP

Yes, those are the big ones, and for all other, there are also associated outcome measures.

Neil Calman – Institute for Family Health – President & Cofounder
Meaning what, Peter?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
... for all of those various associated outcome measures. So, in most states, you have to report your number and rate of—some equivalent of a number or a rate of physical site infections, of catheter-associated infections, of central line-related infections and/or ventilator associated infections, and reporting those as quality measures and facilitating reporting those to simplified state reporting or things that we could talk about.

Leah Marcotte – ONC
Yes, the reporting is, I believe, 23 states require that reporting as of now.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Yes, the number is actually, I just looked it up yesterday, it's 28.

Russ Branzell – Poudre Valley Health System – CIO
So it would seem like if we required that reporting in the system, we could get that hardwired.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Yes, that's exactly right.

Neil Calman – Institute for Family Health – President & Cofounder
So now, that's the reporting of what, exactly?

Russ Branzell – Poudre Valley Health System – CIO
All the monitored infections.

Neil Calman – Institute for Family Health – President & Cofounder
Of monitored—

Russ Branzell – Poudre Valley Health System – CIO
Ventilator, surgical set, I mean, all those types of things out there. I think the real key to this is not just reporting it. It's mandated that it be reported in a specific way.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Yes, and this is something that many of the large vendors are already working on. So we know that this is a feasible thing from the vendor side and the provider side, and it'd be good to get everybody doing it.

Neil Calman – Institute for Family Health – President & Cofounder
That, again, is on the reporting end. Can we go back to the prevention side? We're saying that there's some decision reports and reminders and things that are fairly standard that could be built into these systems, right?

Tripp Bradd – Skyline Family Practice – Physician
Yes.

Russ Branzell – Poudre Valley Health System – CIO
Yes. We have an entire—our organizations probably no different from any others—we have an entire prevention task force, … standard of protocol, and a lot of this is manual today. I'm sure they would appreciate anything in the electronic environment that could help them.

Neil Calman – Institute for Family Health – President & Cofounder
You mean in terms of prevention?

Russ Branzell – Poudre Valley Health System – CIO
Correct.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Yes.

Russ Branzell – Poudre Valley Health System – CIO
This is where it gets out of maybe a little bit less the specific protocols associated with medication and the specific order set, and maybe into more standardized protocol support to ensure these things happen.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
There's a lot of evidence now that standardized, sort of checklisty kind of approaches really help both processes and outcomes in this subject matter. So this would be a very good, very feasible, evidence-based thing to include.

Neil Calman – Institute for Family Health – President & Cofounder
What I'm hearing is that there might be a core set of measures where decision support could be used to reduce hospital acquired infections, and that there's a corresponding need for a standardized reporting mechanism from the systems, right?

Russ Branzell – Poudre Valley Health System – CIO
Correct.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
The other thing that would be good, because this is sort of along the lines of the last conversation we were having about reporting adverse drug events for surveillance purposes, because many states require reporting of at least some of these infections, it'd be good if the EHRs facilitated both the quality reporting to CMS and the state reporting that's already required so that, on the provider side, this could be more efficient.

Neil Calman – Institute for Family Health – President & Cofounder
That's good. I like that. Okay, we've just solved the entire nation's problem of hospital-acquired infections.

Russ Branzell – Poudre Valley Health System – CIO
No, we just know where they all are.

Neil Calman – Institute for Family Health – President & Cofounder
No, first we're going to prevent them all. Then there won't be any to report anymore.

Russ Branzell – Poudre Valley Health System – CIO
There you go. Alright. I'll buy that.

Neil Calman – Institute for Family Health – President & Cofounder
Actually, maybe we should make it in 2013, we prevent them all. That way in 2015, they don't have to be reported. Anything else on infections?

Russ Branzell – Poudre Valley Health System – CIO
I think it would be good for a couple of us that are in the hospitals or offices to actually go and figure out if there are specific things that we can bring back to the group to review on standardized infection protocols or how they're measuring or monitoring that, just so we have some reference point. I'll do that in my organization and get that. I think it'd just be helpful. Maybe that will lead us to some further discussion on infection measurements. I'll do that from my side. If there's anybody else that can provide that, that'd be great.

Neil Calman – Institute for Family Health – President & Cofounder
Does anybody on the call know anything about falls?

Russ Branzell – Poudre Valley Health System – CIO
We actually had an outside consultant come in and help us with our falls protocol reporting requirements and standardization of process and saw a huge drop in critical falls. I think this is going to be almost directly back to a correlation in how we do infection reporting, monitoring, process, that type of stuff. I think it's going to be almost equivalent to that.

Neil Calman – Institute for Family Health – President & Cofounder
Do you have protocols and also a description of what functionality was built into your electronic records system to do that?

Russ Branzell – Poudre Valley Health System – CIO
I can find out how much was put into it. We just went live with the new system last Friday, so I can see what's in there from a falls alerting perspective, especially if— What may be not in our system yet but may be helpful for others is, is there a correlation between certain things that are occurring with that patient that make them a fall risk that the system alerts.

Tripp Bradd – Skyline Family Practice – Physician
Did anyone read or see Peter Brash's very nicely done screen shots of his EHR? Did you guys have a chance to look at it? Having heard none, I would say that what it does is it says it can happen. I know, in the nursing homes, of course, they're … with MDS order sets and stuff. They really do track this very, very acutely.

Now, the hospitals, as Russ had mentioned, do a lot with fall prevention as far as labeling patients, doing education, getting that PT and everything else in. But in the outpatient realm too, Peter Brash gave a nice little summary of how his EHR, which looks like it was kind of custom developed but I think every EHR vendor could do, is in terms of doing, number one, an assessment, even if it was done or not, and actually making a protocol that you do a fall assessment in people over 65, for instance. Or if they have, again, if they're taking a Beers—God forbid you put them on a Beers drug, that they actually have a falls assessment so that you can have those data points actually measured.

Neil Calman – Institute for Family Health – President & Cofounder
He has this pop-up in his system that's pictured. I printed it out.

Russ Branzell – Poudre Valley Health System – CIO
I like the way you put that. I think if there's no populations that are high risk just by definition, then the system should mandate their risk evaluation and protocol be put in place and the system shows that x equals 1 for that individual patient; that that assessment was done and that other high risk individuals, the system supports in the identification of other high risks and correlation to that, a risk assessment was done and protocols were put in place. I'm creating a lot of work for myself, by the way, because all these things I'm talking about, I'm going to have to put in my EMR.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, believe me, we're all looking at it this way. The thing that's interesting about Peter's stuff is it's meant for outpatient setting, right?

Tripp Bradd – Skyline Family Practice – Physician
If you think about it, it preempts the problems that occur in the nursing homes and hospitals. By not having those people on those drugs that they come in and get admitted with, they don't have the falls. You know—

Neil Calman – Institute for Family Health – President & Cofounder
But it's also there's a lot of other pieces to this.

Tripp Bradd – Skyline Family Practice – Physician
Oh, absolutely.

Neil Calman – Institute for Family Health – President & Cofounder
I mean the gate training, the use of assisted devices, environmental hazard assessments. There's assessments of prior falls. There's all this other stuff which is just critical.

Tripp Bradd – Skyline Family Practice – Physician
Right. But just having the measures of a falls assessment and then an intervention would, in every realm, would make a big difference.

Neil Calman – Institute for Family Health – President & Cofounder
So, I don't know of anybody else that's done this. That doesn't mean that nobody else has done it, but I guess the question is how would we want to call this out? Would we want— I guess I don't know if there's a standard way of doing this fall risk assessment. There must be multiple ones.

Russ Branzell – Poudre Valley Health System – CIO
Yes, I work with our quality people here. If you want me to report out between now and next week—I think we have a call next week—or whenever the next one is, and see what I can get. We're pretty intensive in using national benchmarks, so if we're doing something—

Neil Calman – Institute for Family Health – President & Cofounder
Is that inpatient you're talking about?

Russ Branzell – Poudre Valley Health System – CIO
Yes, inpatient specifically.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
I'll work with our injury folks between now and next time and see if they have stuff for us to consider as well.

Russ Branzell – Poudre Valley Health System – CIO
Yes, and if we can get it early, we'll put it out in that SharePoint area and let everybody know it's there.

Neil Calman – Institute for Family Health – President & Cofounder
Does anybody have a shot of doing the same thing on outpatient?

Russ Branzell – Poudre Valley Health System – CIO
I can ask. We've got a family residency teaching program here and if anybody's doing it, it's them. So let me find out from them if they're doing anything in this area.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
Our injury people are likely to know if there's something useful out there. I'll check.

Tripp Bradd – Skyline Family Practice – Physician
There're measures. I'm sure Peter Briss can get that stuff.

Russ Branzell – Poudre Valley Health System – CIO
Whoever's taking minutes and notes for this, if they could make sure we clearly action line what we've got to get done.

Neil Calman – Institute for Family Health – President & Cofounder
Would that be you, Leah?

Daniel
Actually, that'd be Daniel. I do have those flagged, and I'll put those at the top, just like last time.

Neil Calman – Institute for Family Health – President & Cofounder
Okay, great. That's terrific. So, we're going to sort of parking lot that since we don't have a ton of information on it in the small group that's on the call. Hopefully we'll have more by next time.

Why don't we talk about the VTE issue? Do we want to include that somehow in this or would we like to turp it to our Quality Committee? I think it's perfectly reasonable if we want to put VTE in as a fourth item. How do people feel about that?

Russ Branzell – Poudre Valley Health System – CIO
I think that that's a fine place to put that or to do it, but the question is are we going to have anything equivalent to that that really falls into that other category? Again, I think many hospitals are attacking this one in specific. We've been working on this as well, and I think there may be other equivalents of this—

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I mean, our list does not have to be all-inclusive. What we're trying to do is basically identify important domains, but I don't think in any of the areas that anybody thinks that the domains are going to cover the whole field.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
It strikes me that this is an important area. It's the kind of thing that, in principle, it seems like it'd be fairly easily to build in decision support rules, both about initiating treatment, as well as monitoring and stopping it. That it's likely to be a very EHR-sensitive measure that I would favor pitching. I think we heard at the beginning of the call that we don't have to worry too much about, for the purposes of our work, whether that stuff gets ultimately categorized as a patient safety issue or a quality issue.

Neil Calman – Institute for Family Health – President & Cofounder
Exactly.

Russ Branzell – Poudre Valley Health System – CIO
I do have a question on this one. I went over to our physician management site just to see where we put this. We actually put this under our standardized order sets, specifically under drug area for this. Did it just really fall under that first category? I'm not saying we should do it. I absolutely agree we should work on this one. I'm just saying—

Neil Calman – Institute for Family Health – President & Cofounder
We could actually, when we talk about the standardized order sets, we said we were going to try to identify a core number that were critical, so we can hold this until the next meeting and basically decide. But I think we could say that an order set targeted to the prevention of VTE is one of the core that we want to see. But it is definitely part of an order set type of decision support.

Russ Branzell – Poudre Valley Health System – CIO
I will ask our CMO and CMIO if it's okay for me to share this document that I'm looking at and if it is, it might help you all understand what we're looking at here. It might be helpful. I've got a full two page VTE order management environment in here, with all the specifics in it.

Leah Marcotte – ONC
One other issue with VTE prophylaxis is that it gets ordered but then patients don't receive it, that they refuse SubQ heparin the first day and then they're not on SubQ heparin or intermittent percussion devices. So I think that's actually a key. It's a little bit subtle, but it's a key issue that people may or may not want to consider.

Peter Briss – CDC – Medical Director, National Center for CDP&HP
The other thing about this is that it may not be entirely settled by the order sets to the extent that we want to get into monitoring therapy and/or stopping therapy, which I personally would favor. Those things probably won't be handled just with a standardized order set.

Neil Calman – Institute for Family Health – President & Cofounder
Now, is that something that we want to get into? Because that could get pretty complicated, but I'm willing to talk about it. Do we want to get into the assessment of the quality of the anticoagulation and monitoring?

Peter Briss – CDC – Medical Director, National Center for CDP&HP
It seems to me like the argument for it is that we know it's a common problem. We know it's pretty regularly not handled optimally. It seems like both the monitoring and the stopping as well as the starting are things that could be really helped by an EHR that … help with that.

Neil Calman – Institute for Family Health – President & Cofounder
So if you get permission to share that protocol, that would be useful, but I'm wondering if we can't, maybe, try to identify some other protocols as well in this area. Let's highlight that as a follow up item for our next call.

I'm just looking at my list to see if we forgot any of this. We have quite a bit of homework. Are there other areas? We've sort of covered the four that we've called out, that we wanted to put on our top list. I guess the question is in our next meeting what we would do is we would try to develop this into a set of more concrete recommendations. I think we got pretty close in the first category and in infections, and less close in the falls and prevention.

I wanted to just go back for a minute to—I made a little note for myself—about the infection prevention piece. Is there an outpatient part of this that we didn't talk about? I'm not sure I can think of one, but—

Tripp Bradd – Skyline Family Practice – Physician
Well, SBE prophylaxis, but that's almost become a non-issue, and other than that, it would be immunizations which go into population health, which I was looking at, so I can't think of anything.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. I just wanted to make sure we weren't forgetting something there.

Tripp Bradd – Skyline Family Practice – Physician
Can I bring up a safety issue, which sort of goes across most of these, and that's just patient misidentification? I don't know where that fits in safety and whether it's—

Neil Calman – Institute for Family Health – President & Cofounder
It's ultimately part of the national patient safety goal.

Tripp Bradd – Skyline Family Practice – Physician
Right, and I say this because, knowing the behavior in our office before we had pictures in the EHR of patients, with similar named patients, people would go down a long track of taking care of a patient and their problem before they would, almost 100% of the time, pull up and say, "Oh, this is the wrong person." The question I have is, is this something that can be measured and should be part of this process? Of course, I don't think we'll ever get to biometrics, but something that would prevent misidentification. I just bring that up more to brainstorm than to necessarily create a lot of discussion on.

Russ Branzell – Poudre Valley Health System – CIO
Yes. I know just a while back when we were in Washington talking, we had a chance to talk to Dr. Blumenthal. There's a fine line between office or internal organization identification and the need for patient identification systems outside the organization for matching. I know this is an area that significantly struggled, not just the whole country and organizations are struggling with, because there's nothing to match against, and it's one of those you have to have something to be able to use a system to match with. Almost every system has matching information in it, but you're trying to get stuff from somewhere else to match with.

Neil Calman – Institute for Family Health – President & Cofounder
You're talking about importing information and stuff like that?

Russ Branzell – Poudre Valley Health System – CIO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
I think. Is that what you're talking about? Like an electronic way of matching patients electronically?

Tripp Bradd – Skyline Family Practice – Physician
Well, the patient traverses a healthcare system from an office to a hospital to a nursing home, let's say. The identifiers are different, I think, is what Russ is saying. Is that correct?

Russ Branzell – Poudre Valley Health System – CIO
That's correct. We just had a meeting of a group called State Net, which is CIOs representing every state in the country, and 40 of the states were there, and we've all said this is our number one issue, because there's so many things that could be prevented, and improved from an efficiency and clinical care perspective, just if we could get there. We know that it's a political no-no to even suggest a patient identifier standard, never mind the requirement to use an EMPI solution, meaning an electronic matching. Not a specific one, but using that. But maybe that's what we can lead into which is systems have to at least support the ability to appropriately identify a patient.

I absolutely 100% agree with you. I'm not sure who said it at the beginning, but this is the one that keeps us awake every night, from a CIO perspective.

Tripp Bradd – Skyline Family Practice – Physician
Agreed. There should be some parameters that have to be measured, even if it's a picture of the patient, etc. I mean, something. Like I mentioned to you earlier, we've had a lot of near misses in our practice doing that, and identification issue, as Russ mentioned, crosses across every healthcare system type.

Russ Branzell – Poudre Valley Health System – CIO
I wonder, though, now that I'm trying to think through this a little bit, I don't know if it would be incorrect in a protected population, which we have, let's say, within a physician practice, to say that EMR has to have the ability of some type—we're not going to define biometrics or get a credit card—a little equivalent thing or a drive or whatever to appropriately match the patient upon. It really isn't admission into—it is for a health system; it's admission side, but for the outpatient side, when they present. I don't know if that's a bad thing.

Neil Calman – Institute for Family Health – President & Cofounder
Well, I mean, right now in our practice, we have a standard that basically—it's like almost a standard script but it's not really built into the EMR through pictures or anything. It's basically that we confirm somebody's name and their date of birth. It takes ten seconds. Obviously, in primary care, there's people we've been taking care of for 25 years. It gets a little weird if you do that, so we don't enforce it for people who are taking regular care of their regular patients. But, I don't necessarily know that this, except for photography or biometrics, that this is something that's easily EHR-enabled. And if it was, what would we do about our regular patients who come in all the time, who everybody from the security guard to the nurses to the doctors know by their first name?

Tripp Bradd – Skyline Family Practice – Physician
Well, I would say one thing, and it would be easily tracked is, and I'm sure the EHRs can do this and is sensitive, is just having a photograph.

Russ Branzell – Poudre Valley Health System – CIO
Well, you'd be surprised how many don't.

Neil Calman – Institute for Family Health – President & Cofounder

And you'd be surprised how many don't want their pictures in—

Tripp Bradd – Skyline Family Practice – Physician
Yes. Well, I mean, we do use the visual so much in identifying our patients. It makes sense that the EHR should help us do that. Let's say you take a phone call from Russ Branzell and we have ten Branzells, and we pull up something and we see the picture of Russ Branzell, and say, "He's the right guy", or we just click right through it because we don't really— It's just a safety feature, and it is safety and it could be measured, and that's a behavior that, like you mentioned, is the fact of you have to do as part of a protocol or a process.

Russ Branzell – Poudre Valley Health System – CIO
This may go back to what we talked about at the very beginning on the first call, is maybe it's not our job to define the specific measure of this, but rather the standard, which is systems must support the ability to appropriately identify the patient. I mean, that's basic safety 101. Right patient, right record.

Neil Calman – Institute for Family Health – President & Cofounder
So let's just say, what would we say the appropriate methods are?

Russ Branzell – Poudre Valley Health System – CIO
I think we need to do some work on that. I'm not saying parking lot it. I'm just saying I think we've identified, whoever did it, a great area for us for safety, but we need to put a little work to it over the next few weeks.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. So, one thing we measured was a photo.

Russ Branzell – Poudre Valley Health System – CIO
Maybe you start with appropriate demographics with supporting photo and appropriate— I mean, something like that, but I think we just need to work through something like that. Maybe I can talk to one of our EMPI solution providers and say, "Tell me how you do your analytics to determine—when you tell me you are 99% sure this is the right Russ Branzell, tell me how you did that? What are you looking for? Is it birthday and address and phone—?"

Neil Calman – Institute for Family Health – President & Cofounder
Well, it's very different if the patient's in front of you, alive and awake and talking, than it is if you're passing electronic information.

Russ Branzell – Poudre Valley Health System – CIO
We have to remember, though, a lot of patients are not presenting in front of you anymore. They're doing it via telemedicine, they're doing it via phone calls to their providers, e-mails.

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Tripp Bradd – Skyline Family Practice – Physician
Right.

Russ Branzell – Poudre Valley Health System – CIO
This has got to be built in. There are groups now that almost never see their patients anymore.

Neil Calman – Institute for Family Health – President & Cofounder
So we need some voice recognition software so that we can be sure the person who's calling us is really the person who's calling us.

Russ Branzell – Poudre Valley Health System – CIO
No, I wouldn't go that far.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. Well, we can pick up on that.

Tripp Bradd – Skyline Family Practice – Physician
I'm sorry. I didn't want to open this can of worms, but it is a problem.

Neil Calman – Institute for Family Health – President & Cofounder
You did.

Russ Branzell – Poudre Valley Health System – CIO
I think you absolutely got the right one here.

Neil Calman – Institute for Family Health – President & Cofounder
It's in the national patient safety goals, so it's open for taking. Should we ask if there's any more? Any other things you want to put on the list? I think it's perfectly appropriate to explore that further. Okay. Anything else anybody wants to bring up on any part of this topic before we—?

Russ Branzell – Poudre Valley Health System – CIO
The only thing that I was thinking was is there anything in the area of biomedicine that we need to look at, specifically biomedical devices, that's in the safety realm, such as the mandating of auto feeding of physiological monitors, or anything of that nature? The documented, what little I know of it, but the documented research that's out there on the number of incorrect hand entered via computer or handwritten from anything as simple as blood pressures, O2 levels, those kinds of things; when somebody looks at the monitor and then puts it in the system versus the system auto feeding it. I don't think anyone's addressing this at this point, unless I'm missing something.

Neil Calman – Institute for Family Health – President & Cofounder
I've not heard that brought up.

Russ Branzell – Poudre Valley Health System – CIO
I know from our nursing task force, both from the saving of time and ensuring accuracy, that's one of their top initiatives that we need to have running by the end of the year.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. I've definitely heard it brought up as a quality measure, but I've not heard it brought up as a safety issue, in terms of reducing transcribing errors or anything like that.

Russ Branzell – Poudre Valley Health System – CIO
We don't necessarily need to. We can always put it in a parking lot, see if it rears its head some other way later.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. Well, we'll just list it as something else that was brought up at this point. I think that that's fine. So you're talking about an electronic interface of home monitoring? Not just home, but also office monitoring devices?

Tripp Bradd – Skyline Family Practice – Physician
Input devices.

Neil Calman – Institute for Family Health – President & Cofounder
Hospital monitoring devices. Right?

Russ Branzell – Poudre Valley Health System – CIO

Yes. It's those things that are taking electronic feeds of information that aren't being construed as part of the requirement to feed an EMR. We're assuming that human beings are always going to correctly enter that data.

Neil Calman – Institute for Family Health – President & Cofounder
Okay. That's good. Dare I ask if there's anything else? Those are good. Okay. We have an opportunity for anybody that's listening on the public to open up the call for questions. So, Operator, are you on?

Operator
Yes, I'm here.

Neil Calman – Institute for Family Health – President & Cofounder
If we can open up and see if there's any questions from any of the public.

Operator
We do have one from the line of Shelly Spiro.

Shelly Spiro – FASCP – Director
Hello. My name is Shelly Spiro and I am the Director of the Pharmacy EHIP Collaborative. It's a newly formed collaborative of the nine of the professional pharmacy associations. I was listening very intently to your comments as I can see a majority, a large portion of the comments were medication related, and just wanted to offer our assistance in any way to help this particular Tiger Team on information related to medication issues.

Neil Calman – Institute for Family Health – President & Cofounder
Shelly, how can we get in touch with you?

Shelly Spiro – FASCP – Director
We do have a Website and all of my contact information is on the Website. It's www.pharmacye-hit.org. I am the current President of the American Society of Consultant Pharmacists, which is pharmacists organizations in long-term care pharmacy. I was very interested in your talk about falls and falls prevention. This is one of the areas that there is a huge amount of information related to falls within ASCP, and I'd be glad to try to get somebody in contact with you if you needed some more information on falls, especially by senior care pharmacists.

We have a lot of pharmacists who provide services out in the community setting, and have implemented falls programs. There's also a product from our foundation that's called Monitor-Rx that does do risk management on high risk drugs in the elderly, including those that would be related to falls, and also would handle some of the issues that you related to the Beers list drugs. So, there is information out there related to those, and I'll be more than happy to work with the team in any way that we can or get other people to help you.

Neil Calman – Institute for Family Health – President & Cofounder
That would be great. Anything you could forward to us, that would be wonderful. You can be sure we'll look at it and make good—

Shelly Spiro – FASCP – Director
I'm not sure how to forward to you. What do we need to do? So, if somebody could send me that contact information, or let me know how to get that information to you?

Leah Marcotte – ONC
Hi, Shelly. I will send you an e-mail with my contact information.

Neil Calman – Institute for Family Health – President & Cofounder
Great. Thank you very much.

Operator
We do have another question or comment from the line of Donna Glong.

Donna Glong – Nurse
Hi. This is Donna Glong. I'm a nurse and I wanted to request under the never event category if you would consider pressure ulcer risk and also ask you to invite the American Nurses Association to have a representative on the Tiger Team. I think they can lend a tremendous amount of expertise on quality measures related to falls prevention as well as pressure ulcer risk and talk about the HIT sensitivity of those measures.

Neil Calman – Institute for Family Health – President & Cofounder
How can we follow up with that?

Donna Glong – Nurse
Just if I could have your contact? I know that ANA sent a letter to Dr. Blumenthal requesting participation on this team. If there's a way I can get your contact information, I'd be happy to send you further information as well.

Neil Calman – Institute for Family Health – President & Cofounder
Leah, how would you want that done?

Leah Marcotte – ONC
I can just give you my e-mail address right now. Leah.Marcotte@ees.hhs.gov.

Neil Calman – Institute for Family Health – President & Cofounder
Thank you very much for those comments. Are there any other comments?

Operator
We have no more public comments at this time.

Neil Calman – Institute for Family Health – President & Cofounder
In that case, I want to thank the members of the team as well as the folks from the public who are both listening in and those who commented, and we will be collecting as much information as you can. You can see that there's still gaps in our knowledge base, somewhat due to the small number of people that are on the call, but we'll continue to work on this.

We have one more, I believe, Tiger Team call before we're going to report out to the Quality Measures Committee, and so we'll have another opportunity to delve more deeply into the issues that were raised today. So thank you very much, everybody, and have a good weekend.

Russ Branzell – Poudre Valley Health System – CIO
Thank you very much.

Tripp Bradd – Skyline Family Practice – Physician
Thank you.

Leah Marcotte – ONC
Thanks. Bye.

Tripp Bradd – Skyline Family Practice – Physician
Bye bye.